Michigan Cancer Surveillance Program
January 2014 Update

Michigan Abstract Plus Users Update ~

The version of Abstract Plus needed to process NAACCR version 13.0 records, which is ***effective for cases diagnosed prior to 2014,*** is expected to be released by MCSP in late January to mid-February. If you have any questions regarding Abstract Plus, please contact Terry McTaggart at 517.335.9624 or McTaggartT1@michigan.gov.

Instructions for Coding Grade 2014 ~

With the introduction of specialized site-specific grading systems, the coding of grade (Grade, Differentiation or Cell Indicator) NAACCR Item # 440 has become more complicated over time. In addition, the coding instructions listed in CoC's FORDS Manual and SEER's Coding Manual differed. A new set of instructions have been created that are simpler and the same among CoC, SEER and NPCR. No codes have been added or deleted. The 'Instructions for Coding Grade' can be found at http://seer.cancer.gov/tools/grade and are to be ***implemented for cases diagnosed January 1, 2014 and forward***.

MCSP In-house Edits ~

During the Call for Data to NAACCR the MCSP identified several errors that were fairly consistent throughout the data. Please review the coding guidelines for the following data items listed below. For more information on Collaborative Stage (CS) go to http://www.cancerstaging.org/cstage/Pages/default.aspx.

CS METS AT DX AND CS METS AT DX – BONE, BRAIN, LIVER, LUNG

- If the CS Mets at Dx field is coded as 00 (none) the corresponding CS Mets at Dx fields – Bone, Brain, Liver and Lung' must be coded as 0 (none).
- If the CS Mets at Dx field is coded as 98 (not applicable) the corresponding CS Mets as Dx fields - Bone, Brain, Liver and Lung must be coded as 8 (not applicable).
- Coding 00 versus 99:
    - Use code 00 (none) if there is no clinical or pathologic evidence of distant metastases and the patient is not treated as if metastases are present or suspected.
    - Use code 00 (none) if the cell behavior is coded as 2 (in situ).
    - Code 99 may be used in situations where there is reasonable doubt that the tumor is no longer localized and there is NO documentation of distant metastases.
        - Note that code 99 (unknown) maps to MX in the 6th Edition of the AJCC Cancer Staging Manual and cM0 in the 7th edition.

        - Based on the AJCC Cancer Staging Manual, 7th Edition, determination of the clinical M classification (CS Mets at Dx code 00) only requires history and physical examination. Imaging of distant organ sites is not required to assign cM0 or CS Mets at Dx code 00. In other words, the registrar can infer that there are no distant metastases and code CS Mets at Dx as 00 (cM0) unless distant metastases are identified and classified as cM1 or pM1 (or its equivalents in CS Mets at Dx). Note: Code CS Mets Eval as '**0**' (clinical) as this documents minimal physical examination to support the inference of clinical M0.

- Use code 98 (not applicable) for
    - Schemas that do NOT use the CS Mets at DX field
    - Primary sites always coded as 98
        - Hematopoietic, Reticuloendothelial, Immunoproliferative, and Myeloproliferative Neoplasms
        - Hodgkin and non-Hodgkin Lymphoma
        - Kaposi Sarcoma
        - Myeloma and Plasma Cell Disorders
        - Other and Ill-Defined Primary Sites
        - Unknown Primary Site

<u>TUMOR GRADE (GRADE, DIFFERENTIATION OR CELL INDICATOR)</u>

HEMATOPOIETIC AND LYMPHOID NEOPLASMS

The Cell Indicator (Codes 5, 6, 7, 8, and 9) describes the lineage or phenotype of the cell. Codes 5, 6, 7, and 8 are used ONLY for hematopoietic and lymphoid neoplasms. Code 9 indicates cell type not determined, not stated or not applicable.

To code grade for hematopoietic and lymphoid neoplasms, the coding guidelines are as follows:

1. Determine the histology based on the current *Hematopoietic and Lymphoid Neoplasm Manual* at http://seer.cancer.gov/tools/heme/.

2. Determine the Cell Indicator by applying the "Grade of Tumor Rules" within the current *Hematopoietic and Lymphoid Neoplasm Manual*.

Note: If the Cell Indicator is not documented in the patient's medical record, do NOT automatically code grade as 9 (unknown). Frequently physicians do not mention phenotype because they know the phenotype or they understand that the phenotype is inherent in the disease classification name. To determine the grade code, apply the "Grade of Tumor Rules."

TRANSITIONAL CELL CARCINOMA OF THE BLADDER

In transitional cell carcinoma of the bladder, the terminology high grade TCC and low grade TCC are coded using the two-grade system. For TCC, code the grade as follows:

Term	Description	Grade Code
1/2, I/II	Low Grade	2
2/2, II/II	High Grade	4

For cases diagnosed January 1, 2014 and forward, additional information on 'Instructions for Coding Grade' can be obtained at http://seer.cancer.gov/tools/grade. For cases diagnosed prior to 2014, refer to the coding instructions included in the MCSP Cancer Program Manual at http://www.michigan.gov/mdch/0,1607,7-132-2945_5221-16586--,00.html.

PROSTATE (C619)

Please review the following CS site-specific schema notes for prostate cancer cases.

CS EXTENSION – CLINICAL EXTENSION

- Note 1: This field and CS Site-Specific Factor 3, CS Extension - Pathologic Extension, must both be coded, whether or not a prostatectomy was performed. Information from prostatectomy and autopsy is excluded from this field and coded only in CS Site-Specific Factor 3.

- Note 3: Clinically apparent and inapparent tumor. Because code 150 is used to measure screening detected cases, it is important to only apply code 150 when it is clearly an inapparent case. Use the following rules to determine inapparent versus apparent and, when in doubt, use code 300.

  A. A clinically inapparent tumor is one that is neither palpable nor reliably visible by imaging. A clinically apparent tumor is palpable or visible by imaging. If a clinician documents a "tumor", "mass", or "nodule", this can be inferred as apparent. Physician documentation of a digital rectal exam (DRE) that does not mention a palpable tumor/mass/nodule can be inferred as inapparent. This would include findings limited to benign prostate or enlargement/hypertrophy. Do not infer inapparent or apparent tumor based on the registrar's interpretation of other terms in the DRE or imaging reports. A physician assignment of cT1 or cT2 is also a clear statement of inapparent or apparent respectively. Code to 300 (which maps to T2 NOS) in the absence of a clear physician's statement of inapparent or apparent (see also Note 3D).

  B. **Codes 100 to 150** are used only for clinically inapparent tumor not palpable on DRE or visible by imaging, and/or incidentally found microscopic carcinoma (latent, occult) in one or both lobes. Within this range, give priority to codes 130-150 over code 100. Do not use codes 100-140 for needle core biopsy. Use code 150 when tumor is found in one lobe, both lobes, or in prostatic apex by needle biopsy but is not palpable or visible by imaging.

  C. **Codes 200 to 240** are used only for clinically/radiographically apparent tumor/nodule/mass which is palpable or visible by imaging. To decide among codes 200-240, use only physical exam or imaging information, and not biopsy information. Prostate biopsy information is coded in CS Site-Specific Factor 14. Codes 210 and 220 have precedence over code 200. Code 200 has precedence over code 240. Use code 240 if the physician assigns cT2 without a subcategory of a, b, or c.

  D. **Code 300** is used for localized cancer when it is unknown if the tumor is clinically or radiographically apparent. This would include cases with elevated PSA and positive needle core biopsy but no documentation regarding tumor apparency (inapparent versus apparent).

Another example would be a diagnosis made prior to admission for a prostatectomy with no details provided on the initial clinical findings.

E. **Codes 410 to 700** are used for extension beyond the prostate. Information from biopsy of extraprostatic tissue is coded in CS Extension - Clinical Extension (see Note 3 and code 2 on the prostate CS Tumor Size/Ext Eval table for further information).

CS TUMOR SIZE/EXT EVAL

- Note 1: THE CODES FOR THIS ITEM FOR PROSTATE DIFFER FROM THE CODES USED FOR MOST OTHER SITES.

- Note 5: According to AJCC, staging basis for transurethral resection of prostate, TURP is clinical and is recorded as CS Tumor Size/Ext Eval **'1'** (c).

- Note 6: For CS Extension - Clinical Extension codes 100 -150 without prostatectomy assign CS Tumor Size/Ext Eval code **'1'** as these extension codes are only proven by TURP or needle core biopsy.

- Note 7: For CS Extension - Clinical Extension codes 200 - 240 without prostatectomy assign CS Tumor Size/Ext Eval code **'0'** as these extension codes are based on physical examination and/or imaging only and NOT biopsy.

CS SITE-SPECIFIC FACTOR 3 (CS EXTENSION – PATHOLOGIC EXTENSION)

- Note 1: **Include information from prostatectomy and autopsy in this field and NOT in CS Extension - Clinical Extension**. Only use histologic information from prostatectomy, including simple prostatectomy with negative margins, and autopsy in this field. Information from biopsy of extraprostatic sites is coded in CS Extension - Clinical Extension; information from needle core biopsy of prostate is coded in CS Site-Specific Factor 14.

- Note 2: Code '**970'** if there is **no prostatectomy performed within the first course of treatment**.

<u>LYMPH VASCULAR INVASION</u>

Code from the pathology report(s). Code the absence or presence of lymph-vascular invasion (LVI) as described by the medical record.

- Use code 0 when the pathology report indicates that there is no lymph-vascular invasion
- Use code 0 for cases of purely in situ carcinoma
- Use code 1 when the pathology report or a physician's statement indicates that lymph-vascular invasion (or one of its synonyms) is present in the specimen
- Use code 8 for the following primary sites:
    - Hodgkin and non-Hodgkin lymphoma
    - Leukemia's
    - Hematopoietic and reticuloendothelial disorders
    - Myelodysplastic syndromes including refractory anemias and refractory cytopenias
    - Myeloproliferative disorders
- Use code 9 when

- There is no microscopic examination of a primary tissue specimen
- The primary site specimen is cytology only or a fine needle aspiration
- The biopsy is only a very small tissue sample
- It is not possible to determine whether lymph-vascular invasion is present
- The pathologist indicates the specimen is insufficient to determine lymph-vascular invasion
- Lymph-vascular invasion is not mentioned in the pathology report

BLADDER (C67.0-C67.9)
For bladder cancer cases, please review the following site-specific schema note.

CS TUMOR SIZE/EXT EVAL

- Note: According to AJCC, staging basis for transurethral resection of bladder tumor (TURBT) is clinical and is recorded as CS Tumor Size/Ext Eval **'1'** (c).

SEER – Cancer Registrar Training ~

The following training resources are available for cancer registrars by SEER. For more information, visit the SEER website at http://seer.cancer.gov/training/index.html.

- Hematopoietic & Lymphoid Neoplasms Online Training - Educational recordings of presentations for the hematopoietic and lymphoid neoplasms project
- Multiple Primary and Histology Coding Rules Training - Recordings of the online MP/H Rules Training sessions
- SEER*Educate - Online training platform for cancer registry professionals
- SEER Self Instructional Manuals for Tumor Registrars - A collection of instructional manuals in PDF format
- SEER's Training Web Site - Web-based training modules for cancer registration and surveillance
- SEER Advanced Topics for Registry Professionals - An annual event that provides advanced training in data collection and coding. This year's event is to be held **May 15, 2014**.

Electronic Cancer Case Reporting Now Available for Stage 2 Meaningful Use ~

Eligible professionals entering into ***Stage 2 Meaningful Use*** in 2014 will have the opportunity to meet both the Stage 2 cancer reporting objective and the Michigan Department of Community Health's cancer reporting mandate.

Administrative rules authorized by Public Act 82 of 1984 requires physicians, dentists, clinics, hospitals and laboratories that diagnosis or treat patients with reportable conditions to submit cancer case information to the Michigan Cancer Surveillance Program (MCSP). Providers in non-hospital settings using certified EHR (electronic health record) technology now have the option to submit cancer case information electronically, avoiding duplicate data entry and improving the timeliness and completeness of cancer case information reported to the MCSP. **Note that this does not replace the current reporting by hospitals and other health facilities.**

Additional information on Meaningful Use can be obtained from the Michigan Center for Effective IT Adoption at http://www.mceita.org by clicking on link "Resources" and then "Meaningful Use." Or go directly to the Meaningful Use web page at http://www.mceita.org/?page=meaningfuluse.

Eligible professionals interested in reporting cancer case information to meet the Stage 2 Meaningful Use Objective should contact Laura Rappleye at laura.rappleye@altarum.org for further instructions. For information on the cancer case reporting mandate, please contact Jetty Alverson at alversong@michigan.gov or 517.335.8855.

2014 MCSP Educational Workshops ~

The MCSP will be conducting educational workshops throughout 2014. An announcement regarding the workshops will be distributed by the end of the month and posted on the MCSP webpage at http://www.michigan.gov/mdch/0,1607,7-132-2945_5221-16586--,00.html.

MCSP Reporting Requirements ~

All Michigan reporting entities MUST comply with the Michigan cancer reporting requirements. The MCSP Cancer Program Manual and other departmental documents are available on MCSP webpage at http://www.michigan.gov/mdch/0,1607,7-132-2945_5221-16586--,00.html.

Don't forget! If at any time there are changes in your facility contact information, it is the responsibility of the facility to inform MCSP of those changes. A copy of the MCSP Facility Contact Information Form is available on the MCSP webpage.

MCSP Submission of Data ~

Please note the submission of data reminders listed below!

- All cases diagnosed in 2012, MUST be submitted to the MCSP by ***May 31, 2014***.
- Diagnosis year 2013 cases MUST be submitted by ***August 31, 2014***.

NOTE: If your registry is in the SEER area (Wayne, Oakland or Macomb County) and you have questions regarding submission of data, please contact your SEER-State Coordinator, Jeanne Whitlock at 313.578.4219 or whitlock@med.wayne.edu.

MCSP Staff ~

If you have any questions regarding cancer reporting, or would like more information about workshops, please feel free to give one of us a call.

Jetty Alverson	517.335.8855	alversong@michigan.gov
Brenda Bowen	517.335.9058	bowenb@michigan.gov
Glenn Copeland	517.335.8677	copelandg@michigan.gov
Claudia Hardin	517.335.9967	hardinc@michigan.gov
Doug Koster	517.335.8348	kosterd@michigan.gov
Terry McTaggart	517.335.9624	mctaggartT1@michigan.gov
John Mytyk	517.373.0758	mytykj@michigan.gov
Elaine Snyder	517.335.8949	snydere@michigan.gov
Georgia Spivak	517.335.8702	spivakg@michigan.gov
Mary Stephens	517.335.9403	stephensm2@michigan.gov
Wendy Stinnett	517.335.8747	stinnettw@michigan.gov